



UNITED STATES
NUCLEAR REGULATORY COMMISSION
REGION III
2443 WARRENVILLE ROAD, SUITE 210
LISLE, ILLINOIS 60532-4352

January 18, 2024

David P. Rhoades
Senior Vice President
Constellation Energy Generation, LLC
President and Chief Nuclear Officer (CNO)
Constellation Nuclear
4300 Winfield Road
Warrenville, IL 60555

SUBJECT: LASALLE COUNTY STATION - BIENNIAL PROBLEM IDENTIFICATION AND
RESOLUTION INSPECTION REPORT 05000373/2023012 AND
05000374/2023012

Dear David P. Rhoades:

On December 15, 2023, the U.S. Nuclear Regulatory Commission (NRC) completed a problem identification and resolution inspection at your LaSalle County Station and discussed the results of this inspection with John Van Fleet, Site Vice President, and other members of your staff. The results of this inspection are documented in the enclosed report.

The NRC inspection team reviewed the station's problem identification and resolution program to confirm that the station was complying with NRC regulations and licensee standards. The team identified a finding in problem identification, implementation of the process for prioritizing and evaluating these problems, and the effectiveness of corrective actions taken to resolve these problems. Specifically, the team identified a finding with an associated non-cited violation for the failure to follow the requirements of the ASME OM code following a documented test failure of the Unit 1 residual heat removal discharge "C" heat exchanger relief valve. The details of this issue are discussed in the report.

The team also evaluated the station's effectiveness in identifying, prioritizing, evaluating, and correcting problems, reviewed licensee audits and self-assessments, and its use of industry and NRC operating experience information. The results of these evaluations are in the enclosure.

Finally, the team reviewed the station's programs to establish and maintain a safety-conscious work environment and interviewed station personnel to evaluate the effectiveness of these programs. Based on the team's observations and the results of these interviews, the team found no evidence of challenges to your organization's safety-conscious work environment. Your employees appeared willing to raise nuclear safety concerns through at least one of the several means available.

One finding of very low safety significance (Green) is documented in this report. This finding involved a violation of NRC requirements. We are treating this violation as a non-cited violation (NCV) consistent with Section 2.3.2 of the Enforcement Policy.

If you contest the violation or the significance or severity of the violation documented in this inspection report, you should provide a response within 30 days of the date of this inspection report, with the basis for your denial, to the U.S. Nuclear Regulatory Commission, ATTN: Document Control Desk, Washington, DC 20555-0001; with copies to the Regional Administrator, Region III; the Director, Office of Enforcement; and the NRC Resident Inspector at LaSalle County Station.

If you disagree with a cross-cutting aspect assignment in this report, you should provide a response within 30 days of the date of this inspection report, with the basis for your disagreement, to the U.S. Nuclear Regulatory Commission, ATTN: Document Control Desk, Washington, DC 20555-0001; with copies to the Regional Administrator, Region III; and the NRC Resident Inspector at LaSalle County Station.

This letter, its enclosure, and your response (if any) will be made available for public inspection and copying at <http://www.nrc.gov/reading-rm/adams.html> and at the NRC Public Document Room in accordance with Title 10 of the *Code of Federal Regulations* 2.390, "Public Inspections, Exemptions, Requests for Withholding."

Sincerely,



Signed by Ruiz, Robert
on 01/18/24

Robert Ruiz, Chief
Reactor Projects Branch 1
Division of Operating Reactor Safety

Docket Nos. 05000373 and 05000374
License Nos. NPF-11 and NPF-18

Enclosure:
As stated

cc w/ encl: Distribution via LISTSERV®

Letter to David P. Rhoades from Robert Ruiz dated January 18, 2024.

SUBJECT: LASALLE COUNTY STATION - BIENNIAL PROBLEM IDENTIFICATION AND RESOLUTION INSPECTION REPORT 05000373/2023012 AND 05000374/2023012

DISTRIBUTION:

Jeffrey Hamman
RidsNrrDorlLp13
RidsNrrPMLaSalle Resource
RidsNrrDrolrib Resource
John Giessner
Mohammed Shuaibi
Diana Betancourt-Roldan
Allan Barker
David Curtis
Jared Heck
Jefferson Clark
R3-DORS

ADAMS ACCESSION NUMBER: ML24017A120

<input checked="" type="checkbox"/> SUNSI Review		<input checked="" type="checkbox"/> Non-Sensitive <input type="checkbox"/> Sensitive		<input checked="" type="checkbox"/> Publicly Available <input type="checkbox"/> Non-Publicly Available	
OFFICE	RIII	RIII			
NAME	NShah:sw	RRuiz			
DATE	01/18/2024	01/18/2024			

**U.S. NUCLEAR REGULATORY COMMISSION
Inspection Report**

Docket Numbers: 05000373 and 05000374

License Numbers: NPF-11 and NPF-18

Report Numbers: 05000373/2023012 and 05000374/2023012

Enterprise Identifier: I-2023-012-0011

Licensee: Constellation Nuclear

Facility: LaSalle County Station

Location: Marseilles, IL

Inspection Dates: November 27, 2023 to December 15, 2023

Inspectors: E. Magnuson, Reactor Inspector
J. Meszaros, Resident Inspector
N. Shah, Senior Project Engineer
M. Siddiqui, Reactor Inspector

Approved By: Robert Ruiz, Chief
Reactor Projects Branch 1
Division of Operating Reactor Safety

Enclosure

SUMMARY

The U.S. Nuclear Regulatory Commission (NRC) continued monitoring the licensee's performance by conducting a biennial problem identification and resolution inspection at LaSalle County Station, in accordance with the Reactor Oversight Process. The Reactor Oversight Process is the NRC's program for overseeing the safe operation of commercial nuclear power reactors. Refer to <https://www.nrc.gov/reactors/operating/oversight.html> for more information.

List of Findings and Violations

Failure to Comply with ASME Code Requirements Following Test Failure			
Cornerstone	Significance	Cross-Cutting Aspect	Report Section
Mitigating Systems	Green NCV 05000373,05000374/2023012-01 Open/Closed	[P.2] - Evaluation	71152B
The inspectors identified a finding of very low safety significance (Green) and an associated non-cited violation (NCV) of Title 10 of the <i>Code of Federal Regulations</i> (10 CFR) Part 50.55a (f)(4)(ii) for the licensee's failure to perform inservice tests to verify the operational readiness of valves whose function is required for safety. Specifically, the licensee failed to perform inservice testing on two additional relief valves from valve group R105, following the set-pressure testing failure of 1E12-F025C, and failed to perform the cause-and-effect evaluation of the testing failure.			

Additional Tracking Items

None.

INSPECTION SCOPES

Inspections were conducted using the appropriate portions of the inspection procedures (IPs) in effect at the beginning of the inspection unless otherwise noted. Currently approved IPs with their attached revision histories are located on the public website at <http://www.nrc.gov/reading-rm/doc-collections/insp-manual/inspection-procedure/index.html>. Samples were declared complete when the IP requirements most appropriate to the inspection activity were met consistent with Inspection Manual Chapter (IMC) 2515, "Light-Water Reactor Inspection Program - Operations Phase." The inspectors reviewed selected procedures and records, observed activities, and interviewed personnel to assess licensee performance and compliance with Commission rules and regulations, license conditions, site procedures, and standards.

OTHER ACTIVITIES – BASELINE

71152B - Problem Identification and Resolution

Biennial Team Inspection (IP Section 03.04) (1 Sample)

- (1) The inspectors performed a biennial assessment of the effectiveness of the licensee's Problem Identification and Resolution program, use of operating experience, self-assessments and audits, and safety-conscious work environment.
 - Problem Identification and Resolution Effectiveness: The inspectors assessed the effectiveness of the licensee's Problem Identification and Resolution program in identifying, prioritizing, evaluating, and correcting problems. The inspectors also conducted a 5-year review of the core standby cooling systems. The inspection also included a selective review of past NRC observations, violations (including non-cited) and findings documented in the licensee's Corrective Action Program.
 - Operating Experience: The inspectors assessed the effectiveness of the licensee's processes for use of operating experience.
 - Self-Assessments and Audits: The inspectors assessed the effectiveness of the licensee's identification and correction of problems identified through audits and self-assessments.
 - Safety-Conscious Work Environment: The inspectors assessed the effectiveness of the station's programs to establish and maintain a safety-conscious work environment.

INSPECTION RESULTS

Assessment	71152B
Assessment of the Corrective Action Program	
<u>Effectiveness of Problem Identification</u>	
Overall, the station was effective at identifying issues at a low threshold and was properly entering them into the corrective action program (CAP) as required by station procedures.	

During interviews, workers were familiar with how to enter issues into the CAP and stated that they were encouraged to use it to document issues. During plant walkdowns, the team observed that issues were being identified in the field and that they were being properly addressed in the CAP. The team determined that the station was generally effective at identifying negative trends that could potentially impact nuclear safety. For the areas reviewed, the team did not identify any issues in problem identification.

Effectiveness of Prioritization and Evaluation of Issues

In-depth reviews of a risk-informed sampling of action requests (ARs), work orders (WOs), and root and apparent cause and condition evaluations were completed. The team determined that the licensee had established a low threshold for entering deficiencies into the CAP, that the issues were generally being appropriately prioritized and evaluated for resolution, and that corrective actions (CAs) were implemented to mitigate the future risk of issues occurring that could affect overall system operability and/or reliability.

The inspectors noted that issues were properly screened, with most either classified as Conditions Adverse to Quality (CAQ) or Non-Corrective Action Program (NCAP) items. Through a selective review of CAP and NCAP items, the inspectors found no issues either with the assigned level of evaluation or the proposed corrective actions. Issues having potential operability concerns were properly addressed through the screening process and during control room observations, and accompaniment of non-licensed operators during daily rounds; the inspectors did not identify any significant operator workarounds or similar deficiencies.

While most CAP products were acceptable, the inspectors identified some minor examples where the process requirements were not met. These included, but were not limited to:

- A Corrective Action Program Evaluation (CAPE) for AR 4011747 did not have a required effectiveness review as an assigned action.
- AR 4468596 had an incorrect significance level assigned.
- The effectiveness review for root cause evaluation (RCE) associated with AR 4406976 was assigned within 3 months after implementation of the corrective actions to prevent recurrence, which was too early to assess their effectiveness.

The inspectors noted that similar examples were noted in recent licensee self-assessments and audits of the CAP and that actions were being taken by the licensee to reinforce the CAP standards and expectations. The licensee also captured the above inspector-identified examples in the CAP.

The inspectors did a selective review of issues identified by the NRC either documented as observations, or for which findings or other enforcement was issued. These issues were properly documented and screened in the CAP and corrective actions were appropriate and timely scheduled.

Issue evaluations were generally sound and of good quality. Most issues were screened as low significance and were assigned a work group evaluation (the lowest level of review); more significant issues were assigned a CAPE, or if highly significant, a root cause evaluation. Through a selective review, the inspectors verified that the assigned evaluations were consistent with the significance of the issue as defined in the licensee's process.

Most evaluations were generally thorough and consistent with the expectations in licensee procedures; however, the inspectors did identify some CAPEs and RCE evaluations where the quality and depth of the review was less than thorough. Examples included:

- The CAPE for AR 4479498, "1A RR Pump Failed to Downshift and Tripped to 0 Speed," concluded that the event was caused by loose terminal studs on the high speed to low speed auto transfer relay (i.e., GE HFA relays). Specifically, during maintenance on these relays, there was no action to verify the stud tightness prior to returning to service, resulting in some of the connections either being loose or becoming so over time. As a corrective action, the associated maintenance procedures/work packages for the GE HFA relays were revised to include steps to verify the tightness of the terminal stud connections. The inspectors noted that the extent of condition review for this CAPE did not consider other relays that were susceptible to the same condition. As a result, the licensee subsequently identified other relays that should also have been addressed by similar corrective actions.
- The CAPE for AR 4407880, "Spurious Group 4 Signal Causes VG/VR Actuations," identified that the event was primarily due to a technician not using the appropriate controls (i.e., self-check, questioning attitude), when performing maintenance on the system, resulting in the spurious signal; however, the CAPE also discussed issues with the work planning and coordination as having played a significant role. These work planning issues were not identified as a contributing cause and therefore, no action was assigned to identify and address any organizational learnings.

The licensee captured each of these examples in the CAP and had assigned appropriate corrective actions to address the concern.

The inspectors identified a finding of very low safety significance (Green) and an associated non-cited violation (NCV), for the failure to follow ASME code requirements following the set-pressure testing failure of residual heat removal pump discharge relief valve 1E12-F025C. This issue is discussed in more detail later in the report.

Assessment	71152B
Five Year Review of the Core Standby Cooling System (CSCS)	
<p>The inspectors performed an expanded 5-year review of the Units 1 and 2 CSCS; specifically, by performing system walkdowns; evaluating condition reports and work orders; and interviewing personnel responsible for working on the system. The inspectors also reviewed a sample of aging management actions associated with the Unit 1 high pressure core spray (HPCS) room cooler piping, including condition reports, piping replacement plans, and work orders. Overall, the inspectors determined that the licensee was effectively managing issues associated with this system.</p>	

Assessment	71152B
Assessment of Operating Experience and Self-Assessments and Audits	
<u>Assessment of Operating Experience and Self-Assessment and Audits</u>	
<p>Based on the samples reviewed, the team determined that licensee performance in the use of Operating Experience (OE) and Self-Assessments and Audits adequately supported nuclear safety.</p>	

Use of Operating Experience

The licensee routinely screened industry and NRC OE information for station applicability. Based on these initial screenings, the licensee-initiated actions in the CAP to fully evaluate the impact, if any, to the station. When applicable, actions were developed and implemented in a timely manner to prevent similar issues from occurring. During interviews, licensee staff stated that operating experience lessons-learned were communicated during work briefings and department meetings and incorporated into plant operations.

The inspectors did identify one example of OE that was reviewed by licensee staff and deemed as not applicable to the site but was lacking sufficient documentation to support that conclusion. Specifically, AR 467770, "OPEX Review 52007 Vulnerability." The licensee documented this issue in the CAP and reopened the evaluation to add the supporting basis. The inspectors reviewed the additional information and had no further issues.

Although the use of operating experience was seen as valuable, the inspectors identified some instances where it was not properly evaluated as a contributing cause in CAPE or root cause evaluations. Specifically, both the CAPE and root cause guidance procedures stated that OE should be reviewed to determine if there were similar industry events that could provide insights on the issue, including corrective actions, and whether this OE was a missed opportunity for the licensee to have taken prior action to prevent the event. The inspectors identified several examples where the licensee had identified potentially applicable OE but had not fully documented associated learnings from the event, or whether it was a missed opportunity. The inspectors also noted that the licensee had made a similar observation in a prior self-assessment and had identified an adverse trend. This trend was documented in AR 4723092 and the inspectors' examples were added to the AR. The inspectors reviewed the AR and noted that the corrective actions, while in-progress, appeared appropriate.

No findings or violations were identified.

Self-Assessments and Audits

The inspectors reviewed several audits and self-assessments and deemed those sampled as thorough and intrusive with regards to following up with the issues that were identified.

No findings or violations were identified.

Assessment	71152B
Assessment of the Safety-Conscious Work Environment	
<u>Assessment of Safety-Conscious Work Environment</u>	
<p>The team reviewed the station's programs to establish and maintain a safety-conscious work environment and interviewed station personnel to evaluate the effectiveness of these programs. Based on the team's observations and the results of these interviews, workers at the station expressed freedom to raise and enter safety concerns through any one of the various avenues available to them, and the team encountered no indications of a chilled work environment.</p>	
<p>Workers expressed favorable opinions of the Employee Concerns Program (ECP) during interviews. While most workers felt no need to engage the ECP, the inspectors noted that</p>	

there were still several issues documented in the program. Through a selective review, the inspectors concluded that these issues were appropriately handled and identified no adverse trends. The inspectors did note however, that some staff were unaware of where the ECP offices were onsite. This was despite several signs posted throughout the station describing the ECP office location. This was discussed with the ECP coordinator who planned to address this during routine plant department outreach meetings.

Based on the interview results and a review of the ECP issues, the most common issues at the station involved resources and a perception that lower-level CAP issues were not addressed timely. Licensee management was fully aware of these issues, as they had been identified prior in various station self-assessments and audits and in the previous NRC PI&R biennial inspection. The inspectors noted that the licensee had taken action to address these issues. The inspectors also noted that these issues had not had a significant impact on station performance nor had they discouraged licensee staff from raising concerns.

Overall, the inspectors found no evidence of challenges to the licensee’s safety-conscious work environment, as licensee employees were willing to raise nuclear safety concerns through at least one of several means available.

No violations or findings were identified.

Failure to Comply with ASME Code Requirements Following Test Failure

Cornerstone	Significance	Cross-Cutting Aspect	Report Section
Mitigating Systems	Green NCV 05000373,05000374/2023012-01 Open/Closed	[P.2] - Evaluation	71152B

The inspectors identified a finding of very low safety significance (Green) and an associated non-cited violation (NCV) of Title 10 of the *Code of Federal Regulations* (10 CFR) Part 50.55a (f)(4)(ii) for the licensee’s failure to perform inservice tests to verify the operational readiness of valves whose function is required for safety. Specifically, the licensee failed to perform inservice testing on two additional relief valves from valve group R105, following the set-pressure testing failure of 1E12-F025C, and failed to perform the cause-and-effect evaluation of the testing failure.

Description:

The residual heat removal (RHR) pump discharge relief valves (E12-F025A/B/C) at LaSalle station were normally closed valves and had a safety function to open to protect the RHR pump discharge piping in the event of an overpressure condition. The relief valves were set to relieve pressure at 500 psig, as listed in the updated final safety analysis report (UFSAR) Section 6.3.2.2.12. The valves were also required to close to provide containment isolation for the RHR system.

The licensee’s American Society of Mechanical Engineers (ASME) Code of Record for “Operation and Maintenance of Nuclear Power Plants,” (OM) was the 2004 Edition with Addenda through 2006. The licensee categorized the relief valves as Category C valves and tested the relief valves in accordance with Mandatory Appendix 1 of the OM Code.

Mandatory Appendix I Paragraph I-1350(c)(1), required, “for each valve tested for which the as-found set-pressure (first test actuation) exceeds the greater of either +/- tolerance limit of

the Owner-established set-pressure acceptance criteria of I-1310(e) or +/- 3% of valve nameplate set-pressure, two additional valves shall be tested from the same valve group.” Additionally, Mandatory Appendix I Paragraph I-1350(c)(3) states, in part, “the Owner shall evaluate the cause and effect of valves that fail to comply with the set-pressure acceptance criteria established in I-1350(c)(1).”

On May 20, 2022, the 1E12-F025C failed to meet the as-found set-pressure testing acceptance criteria under Work Order (WO) 05240622-04, “EWP MM Perform Testing of Relief Valve 1E12-F025C.” The licensee had replaced the valve with a pre-tested relief valve and entered the issue into the corrective action program (CAP) as AR 4501066, “1E12-F025C WO#5240622-04.”

The inspectors reviewed licensee Procedure LMP-GM-06, “Bench Testing/Setting of ASME OM Class 2 and 3 Safety Relief Valves,” Revision 36, and noted step E.2.3.3 stated, “Initiate an Issue Report. Issue Report must specify that an Action Tracking Item be created for a Causal Evaluation of the failed as-found test.” The Inspectors requested the casual evaluation of the failed as-found set-pressure test, and requested the WOs which performed the inservice testing of two additional relief valves as a result of the 1E12-F025C testing failure.

In response to the inspectors’ questions, the licensee determined they had failed to perform inservice testing on two additional relief valves, and had failed to perform the causal evaluation of the testing failure. The licensee determined they had inadequate WO closure documentation for WO 5240622-04 and had failed to determine the additional scope expansion testing requirements under AR 4501066.

Corrective Actions: The licensee entered this issue into their CAP and planned to perform the additional testing during outage L1R20.

Corrective Action References: AR 04720092, “PI&R Issue – Missed Relief Valve Tests”

Performance Assessment:

Performance Deficiency: The licensee’s failure to perform inservice tests to verify the operational readiness of relief valves, whose functions are required for safety, was a performance deficiency and contrary to 10 CFR 50.55a (f)(4)(ii). Specifically, the licensee failed to perform inservice testing on two additional relief valves from the R105 valve group, following the set-pressure testing failure of the 1E12-F025C valve, and failed to perform the cause-and-effect evaluation of the testing failure.

Screening: The inspectors determined the performance deficiency was more than minor because it was associated with the Equipment Performance attribute of the Mitigating Systems cornerstone and adversely affected the cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Specifically, when a relief valve fails as-found set-pressure testing, the licensee is required to test additional relief valves as a means to address any generic issues which could apply to similar valves in the valve group. The licensee failed to perform set-pressure testing on two additional valves within the valve group, and therefore failed to ensure the availability, reliability, and capability of those additional valves to perform their intended safety function.

Significance: The inspectors assessed the significance of the finding using IMC 0609

Appendix A, "The Significance Determination Process (SDP) for Findings At-Power." The inspectors determined the finding was of very low safety significance (Green) because although the finding was a deficiency affecting the design or qualification of a mitigating structure, system, or component (SSC), the SSC maintained its operability and PRA functionality.

Cross-Cutting Aspect: P.2 - Evaluation: The organization thoroughly evaluates issues to ensure that resolutions address causes and extent of conditions commensurate with their safety significance. Specifically, when the 1E12-F025 set-pressure failure occurred, the organization did not thoroughly evaluate the issue to ensure compliance with all applicable ASME OM Code requirements.

Enforcement:

Violation: Title 10, CFR Part 50, 50.55a (f)(4)(ii) states, in part, "Inservice tests to verify operational readiness of pumps and valves, whose function is required for safety, conducted during successive 120-month intervals must comply with the requirements of the latest edition and addenda of the ASME OM Code incorporated by reference in paragraph (a)(1)(iv) of this section 18 months before the start of the 120-month interval."

The licensee's ASME Code of Record for "Operation and Maintenance of Nuclear Power Plants," is the 2004 Edition with Addenda through 2006.

Paragraph ISTC-5240, "Safety and Relief Valves," states, "safety and relief valves shall meet the inservice testing requirements of Mandatory Appendix I." Mandatory Appendix I, Paragraph I-1350(c)(1), states, "for each valve tested for which the as-found set-pressure (first test actuation) exceeds the greater of either +/- tolerance limit of the Owner-established set-pressure acceptance criteria of I-1310(e) or +/- 3% of valve nameplate set-pressure, two additional valves shall be tested from the same valve group." Additionally, Mandatory Appendix I Paragraph I-1350(c)(3) states, in part, "the Owner shall evaluate the cause and effect of valves that fail to comply with the set-pressure acceptance criteria established in I-1350(c)(1)."

Contrary to the above, as of December 15, 2023, the licensee failed to perform inservice tests to verify the operational readiness of valves whose function is required for safety, in accordance with the requirements of the 2004 ASME OM Code with Addenda through 2006. Specifically, following the set-pressure testing failure of safety-related relief valve 1E12-F025C, the licensee failed to perform inservice testing on two additional valves from the same (R105) valve group, and failed to evaluate the cause and effect of this valve that failed to comply with the set-pressure acceptance criteria established in I-350(c)(1).

Enforcement Action: This violation is being treated as a non-cited violation, consistent with Section 2.3.2 of the Enforcement Policy.

EXIT MEETINGS AND DEBRIEFS

The inspectors verified no proprietary information was retained or documented in this report.

- On December 15, 2023, the inspectors presented the biennial problem identification and resolution inspection results to John Van Fleet, Site Vice President, and other members of the licensee staff.

DOCUMENTS REVIEWED

Inspection Procedure	Type	Designation	Description or Title	Revision or Date
71152B	Corrective Action Documents	1297044	TSP#3 RPS Relay 1C71A-K10C Did Not Deenergize as Required	
		24099401	Results of Failure Analysis on RPV Limit Switch	
		2420487	2C71A-K106G Relay Did Not Open During LOS-RP-Q2	
		4171578	Roll Up IR for RPS TSV Limit Switch Issues	
		4265960	Large Steam Leak Found Downstream of 1G33-F040	
		4404903	2DG01A Heat Exchanger Tubes Material Degradation	
		4406519	NRC ID: Failure to Write IR	
		4406975	Damage in 2B33-F060B Rx Recirculation Flow Control Valve	
		4407109	Unit 2 Refuel Bridge Mast Issue During Fuel Moves	
		4407880	Spurious Group 4 Signal Causes VG/VR Actuators	03/10/2021
		4407906	MSL Tunnel Temp Exceeds 135 F on U1	03/10/2021
		4435863	NOSA-LAS-21-05 NOS Audit of LaSalle CAP	
		4455617	2A RPS Bearing Replacement 4.0 Critique	
		4460065	NRC MD 8.3 Revisions - NRC Incident Investigation Program	
		4468596	RM - U2 Radiochemistry Samples Ind. Presence of Fuel Defect	12/28/2021
		4468963	Level 3 OPEX Review for IRIS# 515757	
		447352	Level 3 OPEX Review for IRIS 515751	
		4474379	Level 3 OPEX Review for IRIS 513205	
		4478972	NOS ID: Parts Control Requires Management Attention	
		4479498	RM-1A RR Failed to Downshift and Tripped to 0 Speed	
		4480457	Level 3 OPEX Review for IRIS 513205	
		4480462	Level 3 OPEX Review for IRIS 518226	
		4481815	Trend IR 1B HX Partition Plate	
		4483962	Eval Required to Leave Scaffold in Place (RWCU Scaffolding)	
		4485486	Level 3 OPEX Review for IRIS# 515457	
		4487513	1WTO1PB 1B TBCCW Pump Degrading Seal	
		4487864	NOS ID: Gaps within CAPE 4407880-10 and Associated Actions	03/28/2022
		4496476	Trend - Incorrect IR Significance Level	

Inspection Procedure	Type	Designation	Description or Title	Revision or Date
		4498422	LPCS Water Leg Pump Leak	
		4500996-42	Perform Risk Assessment for the Eaton Breakers	
		4501066	1E12-F025C WO#5240622-04	
		4507165	NOS ID: Continuing Issues with Parts Control in EMD Shop	
		4522651	B Diesel Fire Pump Coolant Leak	
		4523547	NRC ID: DBAI Design Analysis (EMD) Discrepancy	
		4527147	NRC ID: DBAI Diesel Fuel	
		4527147	NRC ID DBAI: Diesel Fuel Oil Level Calculation Errors	
		4530043	Shepard Calibrator Unsecured	
		4541790	Tagouts Self-Assessment Gap #1	12/09/2022
		4541799	Tagouts Self-Assessment Gap #2	12/09/2022
		4548783	FP SA Review of Completed Fire Protection Permits	01/17/2023
		4548974	FP SA TRM 3.7.k	01/18/2023
		4549245	FP SA Fire Drill in HRFA	01/19/2023
		4549300	FP SA LMS-ZZ-03	01/19/2023
		4549302	FP SA OFP029 Valve Actuator	01/19/2023
		4549364	FP SA LES-FP-05 No Dates	01/19/2023
		4549541	FP SA LES-FP-05 2-22P-01	01/20/2023
		4549546	FP SA LES-FP-05 2-17P-14	01/20/2023
		4549548	FP SA 1-22P-06	01/20/2023
		4549551	FP SA LES-FP-05 Det Zone 1-20	01/20/2023
		4549568	FP SA Fire Drill 23-Q1-01	01/20/2023
		4549615	FP SA Fire Brigade Participation 2021	01/20/2023
		4551562	1A DG Speed Control Governor Not Responding	
		4556006	NRC ID: Fire Door Issue	
		4558566	Level 3 OPEX Review for IRIS# 543717	
		4559142	2E12-F064B Won't Stay Closed	
		4559305	U2 Auto Scram	03/04/2023
		4564302	Trend in Non-Discretionary Clock Resets 2022 to 2023	
		4667295	Level 3 OPEX Review for IRIS #546271	04/03/2023
		4671310	Site Trend in CAP Products Going Overdue	
		4674503	LaSalle County SO and EOC EMNET/NARS Phone Failure	
		4677770	OPEX Review IRIS 525007	

Inspection Procedure	Type	Designation	Description or Title	Revision or Date
		4678390	2A Diesel B/D Starting Air Motors Inline Oiler Not Working	
		4679014	ILT 21-1 NRC Preliminary Results	
		4681955-08	Review of Fleet Events Requiring IRIS Reporting	
		4684120	Maintenance Trend: MMD Attention to Detail	
		4689109	2023 LaSalle Safety Culture Assessment	
		4689109-08	Biennial Fleet Safety Culture Self-Assessment	
		4689631	Level 3 OPEX Review for IRIS #561354	07/10/2023
		4697410	Ops Obj 1 & 2 SA - Simulator UPS	08/19/2023
		4697411	Ops Obj 1& 2 SA - Simulator Post-Event Testing	08/19/2023
		4697412	Ops Obj 1& 2 SA - EO-I Qualification Book Cues	08/19/2023
		4697413	Ops Obj 1 & 2 SA - Objective Alignment	08/19/2023
		4697414	Ops Obj 1 & 2 SA - Operator Fundamentals Reference	08/19/2023
		4697415	Ops Obj 1 & 2 SA - Objective Implementation	08/19/2023
		4697416	Ops Obj 1 & 2 SA - PBIG Development	08/19/2023
		4702449	Level 3 OPEX Review for IRIS# 561471	09/14/2023
		AR 04192778	2018 WANO AFI ER.2	11/07/2018
		AR 04443175	Potential Floatable Material (Snake) Found in U1 RB	08/28/2021
		AR 04498641	Eng. Trend - Leadership Behaviors in Department Improvement	05/09/2022
		AR 04500996	0VE02CA Tripped	05/20/2022
		AR 04505734	Trend in DC Battery Corrosion Issues	06/15/2022
		AR 04513209	L1M24 Critical Path Delay - 35 Hours	07/27/2022
		AR 04536886	NRC RIS 2022-22 Op Leakage Inconsistent w/Op Eval Proc	11/14/2022
		AR 04549213	Level 3 OPEX Review for IRIS# 543773	01/19/2023
		AR 04558586	Potential Trend: L2R19 Failed Welds	03/02/2023
		AR 04701066	RM - LOS-RP-SA4 1C71A-K10G Didn't De-Energize as Expected	09/07/2023
		AR 04720620	1HP55A-4" Pipe Section Replacement	11/30/2023
		AR 2612886	Scope Add Process Not Implemented Properly	01/15/2016
		AR 2618747	LOS-LP-Q1 and A RHR Inoperable is This Necessary?	01/29/2016
		AR 2625698	1A RHR Inoperable Due to Low Pressure	02/13/2016
		AR 2628070	Indication Identified on 1DG02A-10"	02/18/2016
		AR 2628951	Line 1DG05A-4" Was Not Cut in The Correct Location Per EC	02/19/2016

Inspection Procedure	Type	Designation	Description or Title	Revision or Date
		AR 2629265	Rejectable Indication in 1DG02A-10" Weld 3 WO 01326732-02	02/20/2016
		AR 2632624	Division 2 CSCS Issues	02/27/2016
		AR 2693331	LOS-RH-SR1 2B RHR PMP Seal Cooler Flowrate Pre-Test Data	07/15/2016
		AR 2694139	Low Flow Going Through 2B RHR Pump Seal Cooler	07/18/2016
		AR 2695103	License Renewal (LR) Inspections for Selective Leaching	07/21/2016
		AR 2715787	Pipe Downstream of 2E12-F407A is Degraded	09/14/2016
		AR 2716369	Maintenance Rule Unavailability Exceeded for 2-CSCS-DG-06	09/15/2016
		AR 2716731	(A)(1) Action Plan Not Completed Per Schedule	09/14/2016
		AR 3954418	Troubleshoot Cause of Flow Increase	12/16/2016
		AR 3971853	2E12-F386B, Hand Wheel Found Detached Upon Arrival	02/08/2017
		AR 3985811	Maintenance Rule (A)(1) Determination for LAS-0-DG-01	03/15/2017
		AR 3988392	Engineer Evaluate Trend in DG Cooling Water Flow	03/22/2017
		AR 3997974	IR Not Written in a Timely Manner	04/07/2017
		AR 3998308	NDE 1VY03A 2.5" Supply Header UT Readings Below Min.	04/14/2017
		AR 4024726	NOS ID: Non-Consequential Errors in CSCS Hydraulic Model	06/22/2017
		AR 4056244	Level 3 OPEX Review Requested LER 3412017003 Fermi 2	09/27/2017
		AR 4098488	Data Points Do Not Support Welding for 2HP55BB Line	01/29/2018
		AR 4104349	LAS-2-VY-02 Mrule Hours Criteria Exceeded	02/15/2018
		AR 4130434	NOS ID: Active Leak from Drain Line	04/24/2018
		AR 4182775	Preconditioning Eval Request for LOS-RH-Q2, ATT. 1A	10/12/2018
		AR 4221635	VT-3 Exams Specified on Supports Exempted from Examination	02/19/2019
		AR 4233316	2B DG Coolant Leak	03/27/2019
		AR 4236791	CMO Failed to Perform GL 89-13 RHR HX Inspection	04/05/2019
		AR 4257023	Existing Cooler Housing Has Sag	06/14/2019
		AR 4286478	Isolated pit identified on CSCS discharge pipe 1RH83BA-24"	10/09/2019
		AR 4288357	Replace Piping 1DG23B-6"	10/16/2019
		AR 4288399	Flooring and Piping Support Degradation in U2 CSCS Pump Room	10/16/2019
		AR 4316736	Visual Exam Results for ISI Component HPCS DG Cooler 1	02/10/2020
		AR 4322965	Pipe Wall Leak Immediately Downstream of 1FC045B	03/02/2020
		AR 4345863	Extent of condition UT inspection on 2DG23B-6"	05/26/2020

Inspection Procedure	Type	Designation	Description or Title	Revision or Date
		AR 4379968	Localized Corrosion Spots Identified on 1HP54A Piping	10/27/2020
		AR 4382738	Extent of Condition UT Inspection on 1HP54A-4"	11/06/2020
		AR 4401929	2A RHR Pump Seal Cooler Flow Low	02/12/2021
		AR 4404903	2DG01A Heat Exchanger Tubes Material Degradation	02/26/2021
		AR 4410959	NOS ID Final Weld not Inspected in WO 4677538-29	03/23/2021
		AR 4444012	UT inspection on 1RH83BB-24"	09/01/2021
		AR 4477278	NOS ID: Insulation on Valve 2FC045A Crushed	02/10/2022
		AR 4477292	NOS ID: Pipe Support Severely Corroded, Actions Untimely	02/10/2022
		AR 4503287	Level 3 OPEX Review for IRIS# 459111	06/01/2022
		AR 4505723	Level 3 OPEX Review for IRIS# 493320 and 500237	06/15/2022
		AR 4511506	Level 3 OPEX Review for IRIS# 529028	07/18/2022
		AR 4520825	Snake in U1 RB Lower Raceway	09/06/2022
		AR 4538390	LOS-DG-SR7 Acceptance Criteria Not Met	11/21/2022
		AR 4549215	Level 3 OPEX Review for IRIS# 541158	01/19/2023
		AR 4549219	Level 3 OPEX Review for IRIS# 542416	01/19/2023
	AR UT inspection results on 1HP52A-10"	UT Inspection Results on 1HP52A-10"	10/28/2020	
	Corrective Action Documents Resulting from Inspection	4233263	PI&R Identified Issue - Gaps Identified with RCR 4406976	
		4720087	PI&R Issue - IR 4468596 Incorrect Significance Level	
		4720092	PI&R Issue - Missed Relief Valve Tests	
		4720279	PI&R Issue - Legacy Effectiveness Reviews Not Assigned	
		4721459	PI&R Issue - NRC PI&R Identified LVL 3 OPX Issue	
		4722116	PI&R Issue - NRC PI&R Question Regarding CAPE 4479498-07	
		4722154	PI&R Issue - Revise Policy Guidance 139 for Quorum	
		4723257	PI&R Identified Issue - Clarify CA from CAPE 4011747	
		4723263	PI&R Identified Issue - Gaps Identified with RCR 4406976	12/13/2023
		4723313	PI&R Identified Issues - IR How Discovered Incorrectly Coded	
		4723516	PI&R Inspection Issue - Cause from CAPE not Addressed by CA	12/14/2023
4723611		PI&R Inspection Identified - HPCS Degraded Piping	12/14/2023	
4724263	PI&R - NRC Ops Review Lists No Operability Concerns			

Inspection Procedure	Type	Designation	Description or Title	Revision or Date
	Engineering Changes	633646	Lost Parts Evaluation L2R18	002
		637157	Line Kill for RT Heat Exchanger Vent Leaks	
		EC 624352	2VY03A Cooler Tubing Inlet Riser Repair Evaluation	05/23/2018
		TCC 634296	TCCP Temp Setpoint Change for 2B RHR WS Strainer DPS 2E12-N501 From 4 psid to 6 psid	
	Miscellaneous		LaSalle Nuclear Safety Culture Review Meeting Minutes	10/9/2023
		IST-LAS-BDOC-V-26	LaSalle County Generating Station - Inservice Testing Basis Document - 1E12-F025C	03/01/2019
		TP22-2-028	BWROG Reactivity Controls Review Committee (RCRC) Guidelines for Excellence	0
	NDE Reports	Technical Report AH1543-41060080	Long Range Guided Wave Ultrasonic Pipe Screening Results	07/05/2022
		Technical Report AH1548-41076266	Long Range Guided Wave Ultrasonic Pipe Screening Results	07/05/2022
		Technical Report AM1261-343593, AM1295-344407	Long Range Guided Wave Ultrasonic Pipe Screening Results	09/29/2011
		Technical Report AM3116-430677	Long Range Guided Wave Ultrasonic Pipe Screening Results	11/21/2012
		Technical Report AM4103-535476	Long Range Guided Wave Ultrasonic Pipe Screening Results	11/20/2013
		Technical Report AM4103-535476R	Long Range Guided Wave Ultrasonic Pipe Screening Results	01/13/2014
		Procedures	EI-AA-1	Safety Conscious Work Environment
	LEP-HC-103		Refuel Bridge Preventative Maintenance	Revision 18
	LGA-002		Secondary Containment Control	11
	LOS-NB-R2		Reactor Vessel Leakage Test	26
	LOS-RD-SR3		Control Rod Operations	27
	OP-AA-108-115		Operability Determinations	Revision 27
	OP-AA-300-1540		Reactivity Management Administration	21
	PI-AA-115		Operating Experience Program	Revision 6
PI-AA-125-1001	Root Cause Analysis Manual	Revision 7		

Inspection Procedure	Type	Designation	Description or Title	Revision or Date
		PI-AA-125-1003	Corrective Action Program Evaluation Manual	
		PI-AA-125-1004	Effectiveness Review Manual	Revision 2
	Self-Assessments	NOSA-LAS-22-01	Maintenance Functional Area Audit Report	02/23/2033
	Work Orders	1741625-03	EM EWP Special Test 2C71-K4B1 Agastat Relay MR-90	03/09/2021
		5166843-01	RXS - Perform Foreign Material Inspection of Jet Pumps	02/17/2023
		5168984-03	RXS - Inspect & Clean Unit 2 Bottom Head Drain	02/27/2023
		5256192-01	RXS Perform Ultrasonic Fuel Cleaning in L2R19	02/23/2023